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The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs

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The Centers for Medicare and Medicaid Services (CMS) released on August 17, 2007 a letter to state health officials (SHO #07-001) which has major implications for the State Children's Health Insurance Program (SCHIP) and children's health coverage. According to CMS, its directive addresses the potential for crowd-out when SCHIP programs cover children with "effective" family incomes exceeding 250 percent of the federal poverty level, or approximately $52,000 for a family of four. Crowd-out refers to the substitution of publicly funded coverage for private health insurance.

Long-standing federal SCHIP regulations require that states have "reasonable procedures" to deter crowd-out. CMS has indicated in the past that states with eligibility levels of more than 250 percent of the federal poverty level should have strategies in place to deter crowd-out. In the August 17 directive, CMS indicated that states now must implement what it identifies as the five most common strategies to deter crowd-out, and must incorporate three specific components into these strategies. States also must provide assurances that three other conditions are met when expanding coverage to families with gross family incomes above 250 percent of the federal poverty level. (See Table 1 for the specific provisions within CMS's August 17, 2007 directive.)

The requirements in the August 17 directive have raised questions and concerns among states, especially among the 24 states that appear to be affected due to current or recently approved eligibility levels (see Table 2 for a list of states). To date, CMS has not responded in writing to many of the detailed questions about the directive posed by individual states or to questions compiled from states by the National Academy for State Health Policy (NASHP) and submitted at the suggestion of CMS. In February 2008, CMS initiated phone calls in order to discuss compliance with the directive with many of the states previously approved to cover children in families with incomes above 250 percent of the federal poverty level. States and other parties have filed three lawsuits that maintain, among other things, that CMS issued the directive without following the Administrative Procedures Act, which regulates the rulemaking process.

Many advocates for children's coverage are urging Congressional action to prevent the implementation of the directive. Among states and advocates alike, there is concern that aspects of the directive work against achieving the goals of SCHIP and the broader purpose of assuring that children have health coverage and access to quality care.

NASHP has assisted and worked with state SCHIP directors since the program's inception in 1997. At the

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Table 1. Provisions within the August 17 letter from CMS

Common strategies to deter crowd-out

- Impose a waiting period between dropping private coverage and allowing enrollment;
- Impose cost sharing in approximation to the cost of private coverage;
- Monitor health insurance status at time of application;
- Verify family insurance status through insurance databases; and
- Prevent employers from changing dependent coverage policies that would favor a shift to public coverage.

Components to be incorporated as part of identified crowd-out strategies (noted above)

- The cost sharing requirement under the state plan compared to the cost sharing required by competing private plans must not be more favorable to the public plan by more than one percent of the family income, unless the public plan's cost sharing is set at the five percent family cap;
- The state must establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage; and
- Monitoring and verification must include information regarding coverage provided by a noncustodial parent.

Assurances required

- Assurance that the state has enrolled at least 95 percent of the children in the state in families with income below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps taken to enroll these eligible children);
- Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period; and
- Assurance that the state is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements.

Source: Centers for Medicaid and Medicare State Operations, Health Official Letter (Baltimore, MD: U.S. Department of Health and Human Services, August 2007), SHO #07-001.

request of SCHIP directors in states that may be affected by the directive, NASHP convened a workgroup to discuss the provisions contained in the August 17 letter. A number of conference calls were held between January and March 2008 to allow states within the workgroup to discuss the directive, share information, and consider the potential implications of the directive's requirements. As a result of these workgroup calls, NASHP has identified four of the requirements in the directive as causing the greatest concern among states. Most of the affected states believe the directive includes a number of requirements that will be very challenging, and in some cases impossible, to meet.

This *State Health Policy Briefing* examines the four requirements within the directive that are of greatest concern to states. It also provides details and context on CMS's directive requirements, background on current state policy and practice related to each requirement, and a discussion of the issues and implications for states in assessing the feasibility and implications of responding to the new requirements. While this *Briefing* expresses many of the concerns and questions raised by the states in the workgroup, it does not represent all state viewpoints or opinions.

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government.

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Table 2. States affected by the August 17 letter from CMS

State	Program Type	Current Eligibility (Percent FPL)	State Enacted Eligibility - Not Yet Implemented
Federally approved and implemented prior to August 17, 2007			
California	Combination	250	
Connecticut	S-SCHIP	300	
District of Columbia	M-SCHIP	300	
Georgia	S-SCHIP	235	
Hawaii	M-SCHIP	300	
Maryland	Combination	300	
Massachusetts	M-SCHIP	300	
Minnesota	Combination	275	
Missouri	M-SCHIP	300	
New Hampshire	Combination	300	
New Jersey	Combination	350	
New Mexico	M-SCHIP	235	
Pennsylvania	S-SCHIP	300	
Rhode Island	Combination	250	
Vermont	S-SCHIP	300	
State enacted eligibility increases - not yet implemented			
Indiana	Combination	200	300
Louisiana*	M-SCHIP	200	300
New York	S-SCHIP	250	400
North Carolina	S-SCHIP	200	300
Ohio	M-SCHIP	200	300
Oklahoma	M-SCHIP	185	300
Washington	S-SCHIP	250	300
West Virginia	S-SCHIP	220	300
Wisconsin*	M-SCHIP	185	300

Notes: States marked with * have received approval from CMS to increase their SCHIP program's income eligibility to 250 percent of the federal poverty level. As a result of the August 17 letter, these states did not pursue approval for the entire increase approved by their state legislatures.

Sources:

Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Center for Budget and Policy Priorities, Washington, DC and Kaiser Commission on Medicaid and the Uninsured, Washington, DC, January 2008) 10.

Cindy Mann and Michael Odeh, *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive to Impose New Limits on States' Ability to Cover Uninsured Children* (Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families, Dec. 2007) 3.

Assuring a Participation Rate of 95 percent in SCHIP and Medicaid

DIRECTIVE REQUIREMENT

CMS's directive requires states covering children with gross family income above 250 percent of the federal poverty level to assure that they have enrolled in SCHIP or Medicaid 95 percent of children from families with income below 200 percent of the federal poverty level.[1] While states share the goal of maximizing enrollment of eligible uninsured children, there are both measurement and feasibility issues that are raised by this assurance requirement.

CURRENT STATE POLICY AND PRACTICE

Since SCHIP was created in 1997, states have endeavored to increase coverage for low-income children in families with income below 200 percent of the federal poverty level. More

than 90 percent of SCHIP enrollees are from families with incomes in this range.[2] States expend significant resources on outreach to find and enroll these eligible children, and have instituted a variety of measures to improve enrollment and retention practices. The vast majority of children with family income below 200 percent of the federal poverty level who are eligible for either Medicaid or SCHIP are covered.[3]

Additionally, a number of states have found that increasing eligibility to higher income levels has been instrumental in reaching more eligible children in families with income below 200 percent of the federal poverty level. Using existing federal statutory options or through federally approved waivers, many states have established eligibility levels above 200 percent of the federal poverty level for SCHIP. Establishing higher eligibility levels can reinforce the message that children can qualify even if their parents are working and earning low to moderate incomes. Many parents report lack of awareness of Medicaid and SCHIP, as low-income, uninsured children typically live in working households which have little contact with government assistance programs.[4] States have found increasing eligibility levels brings in lower-income children whose families might have been unaware that they were eligible at the lower income limits. As examples:

- Illinois' universal children's coverage program, AllKids, initially enrolled 166,000 children. Approximately 70 percent (114,000) had been eligible previously but uninsured.[5]
- In New York's proposed SCHIP expansion to children in families with income up to 400 percent of the federal poverty level, 93 percent of the additional estimated spending would have been allocated toward covering eligible but unenrolled children in families with income below 250 percent of the federal poverty level (the state's current eligibility limit). New York anticipated a similar experience to Illinois' in getting out the message that it's not just the very poor who qualify for SCHIP.[6]

ISSUES AND IMPLICATIONS

Participation rates are difficult for states to measure. National surveys, such as the Census Bureau's Current Population Survey (CPS), have very small sample sizes for individual states, and many states view their own state estimates as a more accurate representation of the number of uninsured. In addition, survey respondents in the CPS tend to underreport Medicaid or SCHIP coverage (instead saying they have private coverage or are uninsured). Other surveys, such as the Survey of Income and Program Participation or the National Health Information Survey, do not contain recent enough data or have other limitations for measuring participation rates in SCHIP and Medicaid.

CMS has indicated in phone calls with states that it believes there are data approaches that could be used to demonstrate 95 percent coverage of eligible children, including modifications of the CPS to account for underreporting of Medicaid/SCHIP and the inclusion of undocumented immigrants in the survey. The agency has informed some states that a variety of other data sources, including state surveys, could also be used. However, a number of researchers and other experts believe that most states will have difficulty demonstrating 95 percent participation using available sources and methodology.

CMS has not provided a rationale for the 95 percent rate. Since no state, to date, has successfully convinced CMS that it has reached the standard, many believe it is an unrealistic requirement. Even with the most aggressive outreach and enrollment strategies, it is likely to remain a difficult requirement for most states to reach. The participation rates for Medicaid and SCHIP are higher than most other programs targeting low-income Americans. Participation in the federal Food Stamp Program is approximately 50 percent of those eligible, roughly 30 percent below the participation rate for SCHIP.[7] Even in Medicare Part B, in which seniors are enrolled automatically unless they specifically opt-out, the participation rate just exceeds 95 percent (95.5 percent enrolled).[8]

If some states can develop methods to document 95 percent participation rates in their states, many directors would still have concerns about the policy and political implications of using different data for different purposes within a state and across states. Without consistent data definitions and sources, both state and federal policy makers will be denied the most consistent and valid data possible. In addition, some states worry about the potential long-term impact of showing compliance with the 95 percent standard using data or methods that are not accepted universally. By using less than rigorous data or methods, states could adversely impact future SCHIP funding (depending on the allocation formula used).

Establishing a Minimum 12-month Waiting Period

DIRECTIVE REQUIREMENT

CMS's directive requires states to establish – for children with family income above 250 percent of the federal poverty level – a minimum one year period of uninsurance before receiving coverage under SCHIP. Although requiring a period of uninsurance, also known as a waiting period, is not a new concept, states have had the flexibility to determine if a waiting period should be used and how long it should be. At this time, CMS has not indicated whether or not exceptions to the rigid standard, for example, due to death of a parent or involuntary job loss, will be considered.

CURRENT STATE POLICY AND PRACTICE

In accordance with federal policy dating back to 2001,[9] states with SCHIP programs covering children with family income above 200 percent of the federal poverty level are responsible for monitoring, developing, and remaining ready, if necessary, to implement specific crowd-out prevention strategies.[10] In addition, as mentioned earlier, states with eligibility above 250 percent of the federal poverty level must have anti-crowd out strategies in place. Using the flexibility afforded through SCHIP, along with past experiences implementing strategies to deter crowd-out, states have policies in place that are aimed at reducing the likelihood of crowd-out in SCHIP programs.

According to a recent NASHP state survey, the most frequently reported means used to deter crowd-out is a waiting period for children covered previously by a private insurance policy.[11] Although it is unclear at this time how many states will be affected the by August 17 directive, 19 of the 24 states[12] that either provide or propose to provide coverage to at least some children in families with gross incomes above 250 percent of the federal poverty level already use waiting periods. These range from one to six months. However, most states report requiring a six-month waiting period between leaving private coverage and joining SCHIP.[13] All of the states that require waiting periods recognize that there may be reasons for losing private coverage that are beyond the family's control, so they allow exceptions to the waiting periods. The most common exceptions used by states are:

- Loss of insurance due to parent's death, divorce, or an absentee parent dropping coverage;
- Involuntary loss of employment;
- Involuntary loss of employer-sponsored coverage;
- Parent starts a new job;
- When cost-sharing requirements for private insurance are determined to be too expensive, most often defined as ten percent or more of income.[14]

ISSUES AND IMPLICATIONS

As noted, states that utilize waiting periods generally institute the requirement for children who were covered previously by private plans. In general, states have not required children to be uninsured for a set length of time prior to applying for SCHIP, as the CMS directive will require. States are concerned that CMS may be suggesting that regardless of prior coverage status or changed circumstances, children will have to remain uninsured for a year before they are eligible for SCHIP coverage. Many states consider a 12-month waiting period to be an overly broad policy that can have a negative impact on SCHIP's goals to increase coverage and access to care for children.

Requiring children to remain uninsured for a full year prior to enrolling in public coverage, especially if there are no exceptions, increases the risk to their health and development. Gaps in coverage may deny children the preventative and diagnostic care that could have lasting implications for their healthy development. Research indicates the following impacts of uninsurance on children:

- Gaps in insurance coverage result in delayed care, inappropriate care, and costlier care.[15]
- Children with gaps in health care coverage greater than six months have been shown to have the highest rates of unmet needs.[16]
- Compared with those insured for a full year, children with gaps in coverage are less likely to report that they have a usual source of care other than an emergency room.[17]
- Research done in Washington State indicates that uninsured children visited an emergency room more than twice as often during a six-month period as children with no gap in coverage.[18]
- A recent study of New York's SCHIP program indicates that children insured by SCHIP are more likely than uninsured children to have a usual source of care.[19] The study further demonstrates that children without a usual source of care are more likely to have unmet care needs and/or inappropriate visits to the emergency room.

Considering the current and projected state of the economy, states are aware that employers may begin to look for ways to cut their costs, which may result in families los-

ing employer-sponsored coverage or their jobs. Even in good economic times, privately insured children, just like children insured in Medicaid and SCHIP, are prone to coverage interruptions.[20] Public insurance programs can often fill in the gaps in coverage during these durations. If it does not allow exceptions to this one-year waiting period, CMS could be creating a punitive barrier that keeps children uninsured as a result of an economic downturn rather than through their family's willful substitution of public coverage for private coverage.

In addition, a 12-month waiting period may have minimal impact on crowd-out. Research in 2007 by MIT economist Jonathan Gruber and Cornell economist Kosali Simon on crowd-out suggests that waiting periods in states will not lower significantly the crowd-out rate when compared against states with no waiting periods. While there is substitution in SCHIP (and any other coverage option), according to Gruber and Simon, they do not believe that requiring children to wait for coverage will impact crowd-out.[21]

Another concern of states is the significant administrative challenges this provision poses for their programs. For instance, states might be forced to modify or create new applications to address the need for two different standards – children in families with income above 250 percent of the federal poverty level will have a longer period of uninsurance than those at lower incomes if states retain shorter periods for these children. States fear that adopting this policy will further fragment the public health coverage system, which can appear complicated already to the families it serves. Costly technical systems changes may be needed to process applications and determine eligibility (this applies to other directive requirements as well).

Considering the success to date of SCHIP in providing children with important health coverage and the potential the CMS directive has to reverse some of that success, states that could be affected largely view this waiting period provision as poor public policy. Requiring a standard one-year waiting period will reduce the flexibility of states' SCHIP programs, impose unfunded administrative burdens, and will have potential negative consequences for children's health. Also, while states operating separate-SCHIP programs could comply, it is unclear how states operating Medicaid-expansion SCHIP programs could comply, given that federal Medicaid rules govern these programs – and these rules prohibit states from adopting waiting periods. Unless directed otherwise by CMS, states operating Medicaid-expansion SCHIP programs would have to pursue section 1115 waivers to implement a waiting period in order to comply with this provision.

Assuring that Employer-Sponsored Insurance has not Declined by more than Two Percentage Points in the Past Five Years

DIRECTIVE REQUIREMENT

The CMS directive requires that if a state wishes to cover children with gross family incomes above 250 percent of the federal poverty level, it must show that the employer-sponsored insurance (ESI) rate for low-income children has not declined in the state by more than 2 percentage points over the past five years.

CURRENT STATE POLICY AND PRACTICE

States recognize the benefits of private insurance coverage. As discussed, most states have requirements for waiting periods following the dropping of private coverage before a child may be covered by SCHIP. Some states also see premium assistance programs as a means to encourage families to utilize employer-sponsored insurance; nine states operated premium assistance programs in 2005.[22] SCHIP reauthorization legislation attempted to amend the rules to make it easier for states to begin to offer premium assistance for SCHIP enrollees.

Despite their interest in promoting ESI, states have no control over private employers' decisions to offer insurance coverage, as employers are regulated under federal ERISA. States are unable to provide regulatory or oversight assistance for employees working for employers that choose to self-insure. In 2007, 55 percent of employees with ESI were covered under a self-insured plan.[23] And, although they can regulate private insurance companies within their jurisdictions, states cannot change the decisions of individual employers regarding premiums or cost sharing imposed on the employee, or the type of coverage offered.

As mentioned earlier, federal law already requires all states to monitor crowd-out in SCHIP, and also requires states with higher income eligibility limits to have strategies to deter crowd-out (such as waiting periods or cost sharing) in place. Most states have not seen a great deal of substitution at any income level.

ISSUES AND IMPLICATIONS

With few exceptions, most states will be unable to meet

this standard as they have seen a reduction in ESI for all populations and income levels greater than 2 percent over the past five years. The erosion in ESI has occurred for both children *and* adults, a phenomenon believed to be driven by factors other than expansion of public coverage. From 2001 to 2006, the percentage of Americans of all ages with employer-sponsored coverage fell from 62.6 percent to 59.7 percent. For children, the percentage of those covered dropped from 64.4 percent in 2001 to 59.7 percent in 2006.[24]

ESI rates have declined for reasons outside of a state's control. Rising health care costs and premiums have had a great impact on the ability and inclination of employers to offer coverage to their employees.[25] Businesses have responded to rising costs by declining to offer benefits or by requiring more employee cost sharing. This increased cost sharing has forced many families, unable to absorb the increased cost, to drop health coverage. SCHIP and Medicaid have offset the decline in ESI coverage this decade, but there is no clear evidence that public coverage has caused the erosion.[26]

Changes in the U.S. economy this decade also have played a role in declining ESI rates. Fewer Americans are now employed in the manufacturing sector, which historically has had high levels of ESI coverage. More Americans are working in service and construction jobs, which are less likely to offer ESI coverage. In addition, between 2000 and 2004, millions more Americans went to work in small firms or became self-employed, and these groups of workers are less likely to have ESI coverage.[27]

Establishing that SCHIP Cost Sharing be Comparable to that of Competing Private Plans

DIRECTIVE REQUIREMENT

For children with gross family income above 250 percent of the federal poverty level, CMS directs states to adopt a cost-sharing requirement that is comparable (within one percent of the family income) to that of a competing plan sold in the state's private insurance market unless the cost requirement of the public plan is set at the federal cap of five percent of family income.[28] It appears through its directive, that in addition to the already established cost-sharing maximum, CMS is suggesting there also should be a *minimum* cost-sharing requirement.

CURRENT STATE POLICY AND PRACTICE

Of the states that could be most affected by CMS's directive, 22 of them include now or have proposed to include cost sharing within their SCHIP programs for children in families with incomes above 250 percent of the federal poverty level.[29]

ISSUES AND IMPLICATIONS

States are struggling with this requirement, because it too seems to work against the program's goal of providing coverage to uninsured children. Federal guidelines for cost sharing in SCHIP have established a ceiling or a maximum percentage of family income – the five percent of the federal poverty level cap that a state can require a family to pay. Through the directive, CMS is now implying states should maintain a floor or a minimum cost-sharing requirement. This appears to be a significant shift in policy that many states see as working against the goal of covering uninsured children.

Both state experience and research indicate that increasing cost-sharing requirements could reverse the recent strides states have made to reduce churning. Churning occurs when children enroll, drop, and re-enroll in coverage in a short period of time. States have been working to reduce churning by streamlining renewal processes and adopting continuous eligibility policies. Churning creates coverage instability that affects millions of children and families each year, and it exacts a considerable toll on families' ability to access needed health care in a timely and cost-effective setting.[30] For example:

- In January 2002, Rhode Island initiated a monthly premium requirement of 3 percent ($43 to $58) of family income for families with incomes between 150 percent and 250 percent of the federal poverty level. This group made up approximately 10 percent of the total population of RIte Care (the umbrella name of Rhode Island's SCHIP and Medicaid programs). In April 2002, Rhode Island began disenrolling families for failure to pay the premium for two consecutive months. After losing coverage, families were ineligible for RIte Care for four months due to an established four-month waiting period. As a result of the cost-sharing requirement and its enforcement, RIte Care saw a drop in enrollment of 18 percent within three months; more than half of those dropped then remained uninsured.[31,32]

It appears that a state will not be held to the five percent of family income standard if it can prove to CMS that the state's SCHIP cost-sharing requirement is not

more favorable by more than one percent of family income when compared to a competing private plan's cost-sharing requirement.[33] Most states find that comparison to be unfeasible, considering the improbability that child-only coverage is being sold currently within each state's private insurance market. If child-only plans are not on the market, states are left to look at privately sold family plans for comparison. A valid comparison of cost sharing between SCHIP coverage and private family coverage is unlikely, due to the higher cost of adult health care services, which is often balanced by higher cost-sharing requirements within private family coverage. Some states report that CMS has offered a suggestion for calculating the private cost sharing amount for children using an equation to draw it out from the overall amount required for private family coverage. This equation has not been shared publicly, and does not appear to have been tested by external experts.

Compliance with the CMS requirement also may prove to be more difficult for Medicaid-expansion SCHIP programs, because they have less flexibility than separate SCHIP programs. Medicaid expansion programs *must* follow federal Medicaid rules regarding cost sharing unless operating under a Section 1115 waiver.[34]

It is important to note that the following federal requirements apply to all SCHIP programs:

- Cost sharing cannot be required for well-child and well-baby visits;
- Families with lower incomes may not be charged more than families with higher incomes;
- American Indians and Alaskan Natives are exempt from all cost sharing.[35]

Conclusion

The August 17 directive from CMS, released during the debate to reauthorize SCHIP, has raised significant concerns and questions for affected states seeking to cover more children and to manage programs efficiently and effectively. Prior to releasing the directive, CMS did not consult states and has not, to date, provided any additional written guidance for all states currently affected or for those states that may want to cover more of their uninsured children in the future. Many state SCHIP directors believe some or all of the requirements are unnecessary or unattainable, and question the effect they will have on crowd-out. The level of state concern about the directive suggests that review and modification, in consultation with states, is warranted prior to enforcement of the directive as written.

Notes

1 While not defined in the directive, based on state conversations with CMS, the agency's reference to effective income appears to refer to gross income.

2 Chris Peterson and Eliza Herz, *Estimates of SCHIP Child Enrollees Up to 200 percent of the federal poverty level of Poverty, Above 200 percent of the federal poverty level of Poverty, and of SCHIP Adult Enrollees* (Washington, DC: Congressional Research Service, March 13, 2007).

3 79 percent of Medicaid-eligible children and 63 percent of SCHIP-eligible children are covered nationwide. From: Cindy Mann, Michael Odeh. *Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children* (Washington, DC, Georgetown University Health Policy Institute, Center for Children and Families, December 2007).

4 Kaiser Commission on Medicaid and the Uninsured, *Enrolling Uninsured Low-Income Children in Medicaid and SCHIP* (Washington, DC: The Henry J. Kaiser Family Foundation, January 2007).

5 Reported by Theresa Eagleson, Administrator, Division of Medical Programs, Illinois Department of Healthcare and Family Services on July 25, 2007 during the "On-the-Spot: State to State Information Exchange in Illinois" sponsored by NASHP.

6 Reported by Judith Arnold, Director, Division of Coverage and Enrollment, New York Office of Health Insurance Programs on June 6, 2007 in an interview with Barbara Ladon, ArpegioHealth, LLC, for an upcoming paper sponsored by NASHP.

7 Government Accountability Office. *Means-tested Programs:Information on Program Access Can Be An Important Management Tool* (Washington, DC: Government Accountability Office, May 2005).

8 D.K. Remler. and S.A. Glied, "*What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs*," *American Journal of Public Health* Vol. 93, No. 1, 2003: 67–74.

9 CMS. 66 Federal Register 2603. (January 11, 2001). www.frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2001_register&docid=page+2639-2688.pdf.

10 Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, September 2006), 43.

11 Ibid.

12 North Carolina and Ohio have enacted legislation to increase the income eligibility for their SCHIP programs, but are currently undecided regarding their programs' waiting period.

13 Donna Cohen Ross, Aleya Horn, and Caryn Marks, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles* (Center for Budget and Policy Priorities: Washington, DC and Kaiser Commission on Medicaid and the Uninsured: Washington, DC, January 2008), 10.

14 Kaye, Pernice, and Cullen, op. cit., 44-45.

15 Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (Georgetown University Health Policy Institute: Washington, DC & The Commonwealth Fund: New York, NY, June 2006) 14-15.

16 Ibid.

17 Ibid.

18 Ibid.

19 Jonathon Klein, et al., "Impact of the State Children's Insurance Program on Adolescents in New York," *Pediatrics* Volume 119, Number 4, April 2007.

20 Peter Shin, Brad Finnegan, Jessica Sharac, and Sara Rosenbaum. *Health Centers: An Overview and Analysis of Their Experiences with Private Health Insurance* (Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured: Washington DC: January 2008), http://www.kff.org/uninsured/upload/7738.pdf.

21 Jonathan Gruber and Kosali Ilayperuma Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" (January 2007). NBER Working Paper No. W12858 Available at SSRN: www./ssrn.com/abstract=95913

22 Kaye, Pernice, and Cullen, op. cit.

23 Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2007 Annual Survey* (Menlo Park, CA:2007). http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf.

24 Census Bureau figures, http://www.census.gov/hhes/www/hlthins/historic/hihistt3.html.

25 Center on Budget and Policy Priorities, "Is Medicaid Responsible for the Erosion of Employer-Based Health Coverage?" Sept. 22, 2006, accessed at www.cbpp.org/9-22-06health.htm#_ftn6.

26 Ibid.

27 John Holahan and Allison Cook. *Health Affairs* 27, no. 2 (2008): w135–w144 (published online 20 February 2008; 10.1377/hlthaff.27.2.w135)].

28 Under SCHIP federal regulation, total cost sharing, including premiums and co-payments, may not exceed 5 percent of family income. For more information see *Charting SCHIP III*.

29 Kaye, Pernice, and Cullen, op. cit.

30 Summer and Mann, op. cit., viii

31 Ibid., 26

32 RI Medicaid Research and Evaluation Reports. *Results of RIte Care Premium Follow-up Survey*, Issue Brief #4, January 2003.

33 Center for Medicaid and Medicare State Operations, Health Official Letter (Baltimore, MD: U.S. Department of Health and Human Services, August 2007), SHO #07-001.

34 Kaye, Pernice, and Cullen, op. cit., 66

35 Ibid.